

		FOR BHF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0027847</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																							
<b>Facility Name:</b> <u>WINCREST NURSING CENTER CORP</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>010105</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																							
<b>Address:</b> <u>6236 NORTH WINTHROP AVENUE</u> <u>CHICAGO</u> <u>60660</u>																									
<div>NumberCityZip Code</div>																									
<b>County:</b> <u>COOK</u>																									
<b>Telephone Number:</b> <u>7733387800</u> <b>Fax #</b> ( )																									
<b>HFS ID Number:</b> <u>363206916</u>		<table><tr><td rowspan="4"><b>Officer or Administrator of Provider</b></td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4"><b>Paid Preparer</b></td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name &amp; Address) _____</td></tr><tr><td>(Telephone) ( ) Fax # ( )</td></tr></table>		<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Date) _____	<b>Paid Preparer</b>	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) ( ) Fax # ( )												
<b>Officer or Administrator of Provider</b>	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Date) _____																								
<b>Paid Preparer</b>	(Signed) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) ( ) Fax # ( )																								
<b>Date of Initial License for Current Owners:</b> _____																									
<b>Type of Ownership:</b>																									
<table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td><b>IRS Exemption Code</b> _____</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input checked="" type="checkbox"/> "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td>_____</td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td>_____</td></tr></table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other _____	_____
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	<input checked="" type="checkbox"/> "Sub-S" Corp.	_____																							
	<input type="checkbox"/> Limited Liability Co.	_____																							
	<input type="checkbox"/> Trust	_____																							
	<input type="checkbox"/> Other _____	_____																							
<b>In the event there are further questions about this report, please contact:</b>		<b>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b>																							
<b>Name:</b> _____ <b>Telephone Number:</b> ( ) _____																									

Facility Name & ID Number WINCREST NURSING CENTER CORP

# 0027847 Report Period Beginning: 010105 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	24,883	365		25,248	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,883	365		25,248	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.36%

D. How many bed-hold days during this year were paid by the Department?

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO XX

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO X

I. On what date did you start providing long term care at this location?

Date started 1983

J. Was the facility purchased or leased after January 1, 1978?

YES X Date NO

K. Was the facility certified for Medicare during the reporting year?

YES NO X If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH\* CASH\*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 2005 Fiscal Year:

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number WINCREST NURSING CENTER CORP # 0027847 Report Period Beginning: 010105 Ending: 12/31/05

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	94,748	5,698	5,179	105,625		105,625		105,625			1
2	Food Purchase		123,202		123,202	(23,000)	100,202	(1,638)	98,564			2
3	Housekeeping	53,565	31,472		85,037		85,037		85,037			3
4	Laundry	48,602	8,946		57,548		57,548		57,548			4
5	Heat and Other Utilities			55,368	55,368		55,368		55,368			5
6	Maintenance	41,248	13,540		54,788		54,788		54,788			6
7	Other (specify):* ELEVATR REPR		15,070		15,070		15,070	(13,563)	1,507			7
8	<b>TOTAL General Services</b>	238,163	197,928	60,547	496,638	(23,000)	473,638	(15,201)	458,437			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	488,604	10,698	9,003	508,305		508,305		508,305			10
10a	Therapy											10a
11	Activities	94,834	10,774		105,608		105,608		105,608			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* FIRE SAFETY			2,020	2,020		2,020		2,020			15
16	<b>TOTAL Health Care and Programs</b>	583,438	21,472	11,023	615,933		615,933		615,933			16
	<b>C. General Administration</b>											
17	Administrative	204,746			204,746		204,746		204,746			17
18	Directors Fees											18
19	Professional Services			34,779	34,779		34,779		34,779			19
20	Dues, Fees, Subscriptions & Promotions			92,643	92,643		92,643	(660)	91,983			20
21	Clerical & General Office Expenses	126,506	10,303	9,743	146,552		146,552		146,552			21
22	Employee Benefits & Payroll Taxes			152,577	152,577	23,000	175,577		175,577			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,021	1,021		1,021		1,021			24
25	Other Admin. Staff Transportation			6,460	6,460		6,460	(1,000)	5,460			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):* CONTRIBTN			4,000	4,000		4,000	(4,000)				27
28	<b>TOTAL General Administration</b>	331,252	10,303	301,223	642,778	23,000	665,778	(5,660)	660,118			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,152,853	229,703	372,793	1,755,349		1,755,349	(20,861)	1,734,488			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,137	7,137		7,137	5,785	12,922			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			132,391	132,391		132,391		132,391			33
34	Rent-Facility & Grounds			90,000	90,000		90,000		90,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			229,528	229,528		229,528	5,785	235,313			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,152,853	229,703	602,321	1,984,877		1,984,877	(15,076)	1,969,801			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,638)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,000)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(660)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(4,000)	27		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PAGE19	(13,563)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,861)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	5,785		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 5,785		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (15,076)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$ (13,563)	7
2			
3			
4			
5			
6			
7			
8			
9			
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11			
12			
13			
14			
15			
16			
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45			
46			
47			
48			
49	Total	(13,563)	

## Summary A

Facility Name & ID Number	WINCREST NURSING CENTER CORP	#	0027847	Report Period Beginning:	010105	Ending:	12/31/05
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I							

[illegible]

## Summary B

<b>Facility Name &amp; ID Number</b>	<b>WINCREST NURSING CENTER CORP</b>	<b>#</b>	<b>0027847</b>	<b>Report Period Beginning:</b>	<b>010105</b>	<b>Ending:</b>	<b>12/31/05</b>
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**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
FRIEDA BASSMAN	50					
ADEL FARKAS	25					
ERNEST FARKAS	25					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		RENT	\$ 90,000			\$	\$(90,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 90,000			\$	\$ *(90,000)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINCREST NURSING CENTER CORP # 0027847 Report Period Beginning: 010105 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ERNEST FARKAS	OFFCE MGR	ADMINSTR	25.00				SALARY	\$ 48,750	17/1	1
2	ADEL FARKAS	DIR MGR	ADMINISTR	25.00				SALARY	48,750	17/1	2
3	FRIDA BASSMAN	OWNER	ADMINISTR	50.00				SALARY	30,000	17/1	3
4				\							4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 127,500		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number WINCREST NURSING CENTER CORP # 0027847 Report Period Beginning: 010105 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.				\$	126,0791
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	129,5792
3. Under or (over) accrual (line 2 minus line 1).				\$	3,5003
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	128,8904
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	132,3907
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	94,295	8	
		2001	96,732	9	
		2002	97,812	10	
		2003	126,763	11	
		2004	126,079	12	
ACCUAL IS BASED ON PREVIOS YEARS				13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINCREST NURSING CENTER CORP COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0027847

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 14-05-200-020-0000	NURSING HME	\$ 60,130.00	\$ 60,130.00
2. 14-05-200-020-0000	NURSING HME	\$ 62,802.00	\$ 62,802.00
3. 14-05-200-021-0000	NURSING HME	\$ 3,251.00	\$ 3,250.00
4. 14-05-200-0210000	NURSING HME	\$ 3,396.00	\$ 3,395.00
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 129,579.00	\$ 129,577.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		30,000	1983	\$ 70,000	1
2				45,000	2
3	TOTALS	30,000		\$ 115,000	3

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	82		1983		\$ 630,000	\$		\$	\$		4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											9
10	CEMENT WORK			1996	5,500		15	366	366	3,477	10	
11	WINDOWS DOORS			1997	12,899		15	859	859	7,099	11	
12	PLUMBING			1997	43,125		15	2,875	2,875	23,690	12	
13	PLUMBING			1998	22,937		15	1,529	1,529	10,374	13	
14	SECURITY SYS			2000	6,412	376	10	641	265	3,526	14	
15	APLIANCES			2000	6,664	376	10	666	290	3,663	15	
16	FIXTURES			2000	3,320	296	10	332	36	2,157	16	
17	APPLIANCES			2001	7,791		10	779	779	3,116	17	
18	APPLIANCES			2002	4,606		10	460	460	1,840	18	
19	APPLIANCES			2003	3,016		10	302	302	906	19	
20	APPLIANCESA			2004	10,575	1,975	10	1,054	(921)	2,108	20	
21	FIXTURES			2005	5,780	826	10	578	(248)	578	21	
22	APPLIANCES			2005	2,224	445	10	224	(221)	224	22	
23	APPLI			1996	16,513		10	1,651	1,651	14,512	23	
24	APPL			1997	4,586		10	458	458	4,114	24	
25	APPL			1998	1,481		10	148	148	1,190	25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$787,429	\$4,294		\$12,922	\$8,628	\$82,574	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		PONAC		\$14,329	\$1,420	\$(1,420)	\$(2,840)		\$14,319	76
77		BUICK REGAL		20,153	1,420	(1,420)	(2,840)		20,153	77
78										78
79										79
80	TOTALS			\$34,482	\$2,840	\$(2,840)	\$(5,680)		\$34,472	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$936,911	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$7,134	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$10,082	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$5,785	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$117,046	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease.

9. Option to Buy:

YES

NO

Terms:\*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES

NO
16. Rental Amount for movable equipment: \$Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES  
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM  
IN OTHER FACILITY  
COMMUNITY COLLEGE  
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM  
IN OTHER FACILITY  
HOURS PER CNA

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 641,426	\$ 670,927	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	220,782	220,782	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 862,208	\$ 891,709	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		115,000	13
14	Buildings, at Historical Cost		630,000	14
15	Leasehold Improvements, at Historical Cost	72,661	72,661	15
16	Equipment, at Historical Cost	295,617	295,617	16
17	Accumulated Depreciation (book methods)	(273,292)	(903,292)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): GOODWILL		1,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 94,986	\$ 210,986	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 957,194	\$ 1,102,695	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 104,728	\$ 104,728	26
27	Officer's Accounts Payable	256,802	256,802	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	128,890	128,890	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 489,970	\$ 489,970	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 489,970	\$ 489,970	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 467,224	\$ 612,725	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 957,194	\$ 1,102,695	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 511,445	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 511,445	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(24,221)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(20,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (44,221)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 467,224	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number WINCREST NURSING CENTER CORP # 0027847 Report Period Beginning: 010105 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,955,524	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,955,524	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,132	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,132	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,960,656	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services		31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,984,877	40
41	Income before Income Taxes (line 30 minus line 40)**	(24,221)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (24,221)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 40,731	\$ 19.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	8,665	9,028	181,285	20.08	4
5	CNAs & Orderlies	28,027	30,032	266,588	8.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,181	19,632	9.00	9
10	Activity Assistants	7,461	8,355	75,202	9.00	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,294	1,334	12,014	9.01	14
15	Cook Helpers/Assistants	9,091	9,791	82,734	8.45	15
16	Dishwashers					16
17	Maintenance Workers	3,676	4,124	41,248	10.00	17
18	Housekeepers	3,895	6,695	53,565	8.00	18
19	Laundry	4,420	4,816	48,602	10.09	19
20	Administrator	2,000	2,000	77,246	38.62	20
21	Assistant Administrator	4,000	6,020	127,500	21.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,341	16,246	126,506	7.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,870	102,702	\$ 1,152,853 *	\$ 11.23	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 5,179	1/3	35
36	Medical Director				36
37	Medical Records Consultant		2,080	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant		2,000	10/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,923	10/3	45
46	Other(specify)				46
47	FIRE SAFETY CONS		2,020	10/3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,202		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
ERNEST FARKAS		25	48,750	Workers' Compensation Insurance	\$	40,880	IDPH License Fee	\$ 200
ADEL FARKAS		25	48,750	Unemployment Compensation Insurance		19,386	Advertising: Employee Recruitment	6,620
FRIEDA FARKAS		50	30,000	FICA Taxes		88,194	Health Care Worker Background Check	\
NERAD RESONLINGH	ADM		77,246	Employee Health Insurance			(Indicate # of checks performed )	
				Employee Meals		23,000	CITY LICENSE	1,100
				Illinois Municipal Retirement Fund (IMRF)*			IL COUNCIL DUES	6,020
							IL FISCAL BUREAU	47,169
TOTAL (agree to Schedule V, line 17, col. 1)				HEAD TAX		3,117	PENSION	10,604
(List each licensed administrator separately.)			\$ 204,746	CHRISTMAS EXP		1,000	EMPLOYEE HEALTH INS	20,930
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	( )
			\$				Non-allowable advertising	(660)
							Yellow page advertising	( )
				TOTAL (agree to Schedule V,	\$	175,577	TOTAL (agree to Sch. V,	\$ 91,983
				line 22, col.8)			line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
LANCE WISE	CPA		30,000					
HARVEY GOLDSTEIN	Legal		1,000					
PAYROLL SERVICE	PAYROLL SERVICE		2,933				In-State Travel	
KEN DITKOWSKI	Lawyer		846					
							Seminar Expense	
							Entertainment Expense	( )
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	\$
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 34,779				TOTAL	

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	ELEVATOR REPAIR	06/2006	15,070	5				1,507					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 15,070		\$	\$	\$	\$ 1,507	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? NO
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? 10YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? \_\_\_\_\_  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ \_\_\_\_\_  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? \_\_\_\_\_ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ NO  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training?** \_\_\_\_\_  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.